DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 11/09/13

PRINTED: 09/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445295	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLSTON MANOR	3641 MEMORIAL BLVD KINGSPORT, TN 37664

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.70(a) K3 BUILDING: 1-story Type V(111), combustible construction with a complete automatic sprinkler system. K6 PLAN APPROVAL: ~1976 K7 SURVEY UNDER: 2000 EXISTING K8 204-bed SNF/NF	K 000		
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure four (4) hour fire rated construction is maintained. The findings include: Observation and interview with the Maintenance Director, on September 23, 2013 at 2:00 p.m. confirmed two, large unsealed penetration in the 4-hour firewall from the kitchen to the dry storage room. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on September 23, 2013.	K 012	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact exist. This Plan of Correction if filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care. K 012 1. The two large penetrations in the 4-hour firewall have been repaired by the Maintenance Director. 2. A complete inspection of the facilty's 4-hour firewalls has been performed to assure that there are no other penetrations. 3. Monthly Inspections will be performed by the Maintenance Director. 4. The results will be reported to the Quality Assurance Committee for Three (3) months.	11/09/2013
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10/14/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors closed to a positive latch. The findings include: 1. Observation and interview with the Maintenance Director, on September 23, 2013 at 12:15 p.m. confirmed the door to resident room 624 failed to close to a positive latch. 2. Observation and interview with the Maintenance Director, on September 23, 2013 at 12:15 p.m. confirmed the fire door by room 601 had one side that was not provided with latching panic hardware. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on September 23, 2013.	K 018	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact exist. This Plan of Correction if filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care. K 018 1. The Door latch to room 624 was adjusted for proper closing and latching.Latching panic hardware has been installed on the Fire Door by 601 and adjusted for proper closing and latching. 2. All resident room doors were observed and no other doors were affected. 3. Staff was in-serviced by Maintenance Director in proper closing requirements and notification for repairs as needed. 4. Door will be observed during the fire drills and monthly inspection by Maintenance Director and/or his designee and reported to the Quality Assurance Committee for Three (3) months.	11/09/2013
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

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K 029	Continued From page 2 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were maintained. The findings include: 1. Observation and interview with the Maintenance Director, on September 23, 2013 at 10:15 a.m. confirmed the storage room next to the environmental service office was not provided with door closers (NFPA 101, 19.3.2.1 (7). 2. Observation and interview with the Maintenance Director, on September 23, 2013 at 10:15 a.m. confirmed the following areas had unsealed penetrations in a 1-hour rated assembly: a) Sprinkler riser room ceiling b) The 300 hall soiled utility room had unsealed plumbing penetrations in the wall by the hot water heater, c) Electrical room (100/200 hall) ceiling above the main breaker. These findings were verified by the Maintenance	K 029	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact exist. This Plan of Correction if filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care. K 029 1.Door closures have been installed on the storage rooms door next to the Environmental Services office.The unsealed penetrations in the sprinkler riser room ceiling, the 300 hall soiled utility room pluming in the wall by the hot water heater and the 100/200 hall ceiling above the main breaker have been sealed by the Maintenance Director. 2. A complete Facility audit of all doors requiring door closures has been performed and corrected as appropriate. 3. All Facility plumbing penetrations have been inspected to ensure that none are unsealed. 4. The Maintenance Director and/or designee will inspect monthly to ensure door closures are connected and working property as well as all ceiling and pluming penetrations are sealed The results will be reported to the Quality Assurance Committee for Three (3) months.	10/31/2013 11/09/2013

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K 029	Continued From page 3 Supervisor and acknowledged by the Administrator during the exit conference on September 23, 2013.	K 029		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, it was determined fire dampers were had not been maintained in accordance with NFPA 90A. The findings include: 1. Record review and interview with the maintenance director on September 23, 2013 at 1:30 p.m. confirmed the facility failed to provide documentation to show the 4-year required maintenance to fire dampers had been performed. The Maintenance Director stated it had been done last year but couldn't find the paperwork 2. Observation of fire dampers in the 4-hour fire wall by the medical records office on September 23, 2013 at 4:30 p.m. confirmed the fusible link was separated and the linkage was wired open preventing the fire damper from closing in the event of fire. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on September 23, 2013.	K 067	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact exist. This Plan of Correction if filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care. K 067 1. The Fire Dampers in the 4-hour Fire wall was replaces and the documentation for the Fire. Dampers 4-year required maintenance has been found and placed in the administrator's office. 2. An inspection of Facility Fire Dampers was performed and no other Dampers are compromised. 3. A preventive maintenance log will utilized to ensure compliance and that no links have been compromised. 4. The Maintenance Director will report inspections to the Quality Assurance Committee.	11/09/2013

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K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical panels had the required clear 3-feet space in front of them (NFPA 70,110-16 (d)). The findings include: Observation and interview with the Maintenance Director, on September 23,2013 at 11:35 a.m. confirmed there was a housekeeping cart in front of the electrical panels in the main electrical room and paint storage cabinets in front of electrical panels in the sprinkler room. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on September 23, 2013.	K 147	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact exist. This Plan of Correction if filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care. K 147 1.The housekeeping cart and the paint storage cabinets have been removed by Environmental Services. 2.All other electrical panels in the facility have been inspected to ensure they are clear Three (3) foot of space in front of them. 3.Staff was in-serviced as to the requirements of space. 4. Electrical panels clearance inspections will be placed on a monthly PM log and reported to Quality Assurance Committee for Three (3) months.	11/09/2013